ER SENIOR RESIDENT

Updated April 16, 2025

Table of Contents

ER Resident Role

This is the senior resident on the GIM team doing overnight or weekend call.

A) Responsibilities:

1. On call to the Emergency Department for General Internal Medicine (GIM) Consults
    a. Weeknights: takes pages 5pm until 8am
    b. Weekends:
        i. Daytime Consults Resident takes pages from 9am until 4:30pm
        ii. Overnight SMR takes pages from 4:30pm until 9am (8am on Monday)

    ***there is NO rotating pager so these will go to your personal pager**
2. **Weekend days only:** on call for new GIM consults for admitted patients
    a. Daytime Consults Resident is first call from 9am to 4:30pm. Consults after 4:30pm will go to the MCR
3. Code Blue team leader 5pm-8am (9am weekends)
    a. Pager to be picked up from **D416 alcove** at 5pm from ***Silver*** Hospitalist Fellow and handed over at same location at 8/9am
4. Back-up for ward issues to your own team (especially if team is covered by a medical student).

B) Not responsible for:

1. This resident does NOT do consults for patients who are already admitted under another **service (with the exception of GIM consults on weekends from 9am to 4:30pm)**. This is the MCR resident.
2. You do not cover consults to the ER if a non-medical service (i.e. surgery) requests a medical consult before discharging a patient from the ER. These cases should be seen by the MCR Resident. **The only exception to this would be if it sounds like there is no way the patient can go home AND they also sound like they should be admitted to medicine.** Then you should see the patient.

Guidance for Senior Call at Sunnybrook

1. ER Referral (Admission) Guidelines

a. Remember that these are only guidelines, not rules. If there is any disagreement about which service should admit a patient, please involve your staff **early**. This is their responsibility to work out with the other service(s), not yours. The guidelines can be found here: https://drive.google.com/file/d/1cI8O2GhKFfKyeU6EfPRG0uuOEh7lOH-E/view

2. Receiving Consults

a. When receiving a consult, have SunnyCare open and review the patient's records. Check both the Encounter and Transcription lists. This is helpful to determine if a patient is known to Oncology, a particular subspecialty, or recently discharged from another service. If this is the case, it is easier to discuss this with the ER doc over the phone to see if they think the consult is more appropriate for one of these services.

3. Level 1 ICU Beds on C4

a. Beds will be allocated **3 each to Blue and Green CTU Teams**
b. These beds can accommodate the following:
    i. Vitals, suctioning or bloodwork more frequently than q4h, but not exceeding q2h
        1. e.g. hyponatremia, DKA, seizures, alcohol withdrawal, ALS, **uncuffed** tracheostomies
        2. Note: Subcutaneous DKA protocol must also go to a Level 1 bed (i.e. cannot go to ward)
    ii. BiPAP

1. E.g. CHF or COPD exacerbations ***EXCEPTION: AS OF MARCH 2026 L1 BEDS CANNOT ACCOMODATE NEW START BIPAP OR HFNC IF PT IS FULL CODE**

iii. ALS patients on home BIPAP who are presenting with a respiratory illness, or ALS patients being admitted for G-tube insertion
1. Stable patients awaiting G-tube insertion must be admitted to a Level 1 bed because they are at risk for deterioration post-procedure. ALS patients being admitted for other reasons can be admitted to CTU.

iv. No: intubation/ventilators, arterial lines, pressors, antihypertensive infusions

v. *You can call bed flow or ask the Blue/Green resident on call if a bed is available. Bed flow may also be able to assist with making a bed available if a patient is ready for transfer out of Level 1 to the ward to accommodate a new admission.

vi. We cannot accommodate cuffed trachs (even if cuff down) on L1 or on the ward

c. The On-Call staff should be notified of **ALL** admissions/transfers out of Level 1 in **real-time** overnight, and should be involved for ANY concerns with suitability for admission or clinical stability, including if you are trying to open up a Level 1 bed overnight with bedflow

d. **Note:** A maximum of **4** Respiratory patients with HFNC/BiPAP/Trach can be in the Level 1 beds

e. C4 GIM Level 1 Inclusion/Exclusion policy: https://drive.google.com/file/d/1bpRDo-WbjeDCLiuZ-1ZMMPdeNh50zeMl/view

f. Starting Oct 1 2025, we are running a pilot project where patients being admitted to L1 for DKA can be admitted even if there is no L1 bed available (they will be cared for in the ED until a bed becomes available).

g. L1 transfers overnight (e.g. from Red Team to Blue Team)

i. Steps:
1. Red team JMR discusses with SMR + Red Team staff re moving the patient into L1
2. Red team JMR writes L1 transfer orders and hands over to Blue team resident
3. Blue team JMR assess the patient once in the L1 bed, writes a new consult note (because MRP has changed) and adds additional orders if necessary
4. GIM staff on call should be made aware of the transfer

4. FiO2 Policy

a. There is no specific policy/cutoff for ward oxygen levels, however rapidly increasing requirements and/or FiO2 50% or greater should prompt consideration of escalation of care and Rapid Response involvement

b. For High Flow Nasal Cannulae (HFNC), the following policy applies:
1. Patients who are **FULL CODE** cannot be started on the ward, but patients may be transferred out of ICU once they fulfill the following criteria:
   - Stable on a FiO2 at or below 0.5 for 24 hours
   - Appropriate for vital sign assessment at 4 hour intervals
   - Does not require ICU for other indications
2. Patients who are **NOT FOR INTUBATION** can be started on the ward or transferred out of ICU with no limitations on their FiO2 requirement once they fulfill the following criteria:
   - Appropriate for vital sign assessment at 4 hour intervals
   - Does not require ICU for other indications
   - Have the appropriate order sets in the chart:
     - No Intubation for their Life Support Interventions order set (PR 14186)
     - No Cardiopulmonary Resuscitation order set (PR 14187)
3. Patients who are for **COMFORT MEASURES** can be started on the ward or transferred out of ICU with no limitations on their FiO2 requirement once they fulfill the following criteria:
   - Have the appropriate order sets in the chart:
     - No Intubation for their Life Support Interventions order set (PR 14186)

        - No Cardiopulmonary Resuscitation order set (PR 14187)
        - Comfort Measures for Imminently Dying Patients order set (PR 50050)
    i. The official HFNC policy for ward patients can be found here: https://sunnynet.ca/default.aspx?cid=130923

c. In all cases, a ward level patient **cannot** have monitoring requirements greater than q4 hours, regardless of FiO2. If a patient requires more frequent monitoring, transfer to a Level 1 or higher ICU bed should occur if congruent with goals of care.
d. Level 1 ICU patients with FiO2 requirements 60% or greater should have a Rapid Response/ICU consult for consideration of escalation of care, if congruent with goals of care
    i. Note: a maximum of **4** respiratory patients may be admitted to the C4 Level 1 ICU at any given time due to nursing ratios

5. Fractures

Fractures: If the reason for admission is a fracture or inability to ambulate secondary to a fracture, the patient should be admitted to Orthopedics. The exception is vertebral compression fractures as outlined below. If the patient is medically unstable, Critical Care should be consulted. If there are other medical issues that need to be addressed, the orthopedics team can consult GIM Consults (MCR resident).

a. If the patient has a fracture that does not require admission or surgical intervention and the primary reason for admission is medical, the patient should be admitted to medicine. For example, if a patient has a syncopal episode concerning for a cardiac cause needing inpatient workup, but also has a distal radius fracture with no plan for surgery or otherwise limiting ability to go home, that patient should be admitted to GIM for their syncope workup. If there is uncertainty about the best admitting service, the GIM staff should be involved early to help determine the best disposition for the patient.
b. Vertebral Fractures without neurologic deficits who require admission: they get admitted on ODD days to Internal Medicine and on EVEN days to the Spine Service. **This is determined by the day of REGISTRATION not the day of referral**, i.e., the patient was registered in ER on December 13th and would be admitted to Internal Medicine even if you are called to assess on December 14th.

6. Oncology Patients

a. **Followed at Odette Cancer Centre**: if they present with a *complication of their malignancy or therapy* they get admitted to Oncology, i.e. sepsis, VTE, hypercalcemia, seizures, etc.
b. Patients with a new diagnosis of cancer or NOT followed at Odette: seen by and admitted to GIM

7. Ischemic Limb

Only admitted to GIM if the patient declines surgery or BOTH orthopedics (for amputation) and vascular surgery (for revascularization) decide surgery is not an option for this patient. This needs to be documented in the chart. If it is not certain whether surgery is going to be offered, and the dysvascular limb is not acute, and the patient has other medical issues, GIM may be the appropriate service; should probably be discussed with staff.

8. Patients Accepted in Transfer from Another Hospital by Another Service

These patients are the responsibility of that service. If the problem turns out to be non-surgical (ie. non-operable intracranial bleed), they are not then sent to GIM. If the patient has medical issues requiring inpatient care, the options are:

a. Admit to accepting service with Medical Consults service to follow
b. Accepting service to send patient back to referring hospital

Contact the GIM Staff on call if there are any concerns about this process.

9. "Bounce Backs"

Refers to any patient **discharged from Medicine within the last 48 hours (Sunnynet page: https://sunnynet.ca/default.aspx?cid=111477)**. The triage nurse will call you to let you know the patient is back in the ER. This patient will ONLY have triage vitals done. ***They will not be seen by a physician prior to you*.** This patient should go back to the team they were just discharged from if they require admission.

For 'bounce-backs' of longer duration, (i.e. within the same resident block but longer than 48 hours) who need readmission to GIM, they should return to the prior team IF the house staff hasn't changed over. Of note there is no bounce back for orange or purple team, as the fellow covering these beds cannot leave K3 and come to ED out of hours, and there needs to be a physically open bed. If the patient is stable for K3 AND there is an appropriate open bed, they can be readmitted to those teams. If there is NOT an open bed, then they should be admitted to any of the other teams.

Patients recently discharged from a surgical service needing readmission should usually go back to that service. If the problem now seems "medical", the patient still goes back to them so long as the problem is a probable postoperative complication or was already an issue during their Surgery admission. For example, a postoperative pneumonia developing shortly after discharge goes back to Surgery (with a GIM Consult PRN).

On the other hand, a hip fracture patient discharged from Orthopedics three weeks earlier, who presents now with CHF or pneumonia should probably come to Medicine. But a patient with delirium who was noted to be delirious even before discharge goes back to their surgical service. These principles also apply to **patients followed as outpatients by surgical services**. Issues arising due to complications of therapy or progressive disease remain the responsibility of the service previously providing care for the patient. The current MAC guidelines clearly state "The service's lack of any further active treatment to offer a patient **does not supersede the importance of continuity of care** provided by the service's physician for the patient."

10. Rapid Referral Clinic (RRC)

If the patient sounds like they do not need admission, you can ask the ER doctor if they feel comfortable referring them to the Rapid Referral Clinic. If they are comfortable with this plan, they can do this online (not you) and the patient will be seen typically within 24-72 hours. When in doubt, please see the patient and complete a consult. If the patient is ultimately discharged from ED, they can be seen in the Post Discharge clinic for further follow up, if required, which should be discussed with the on call staff prior to discharging the patient.

11. Sending Patients Home from the ED

Call the on-call GIM staff overnight to review. You can book the patient a follow up appointment in the Post Discharge Clinic (not RRC) if you want to follow up on an issue or test. To do this, email Postdischarge.rrc@sunnybrook.ca with the following information:

a. Patient's name and MRN
b. Date and Time of appointment (pick any afternoon between 1-3 pm)
c. Resident's name who will be seeing the patient and pager ID
d. Supervising staff physician

You should let the patient know their appointment date/time and clinic location (**CG-13**).

12. Consult for Medical Clearance

You do not cover consults to the ER if a non-medical service (i.e., surgery) requests a medical consult before discharging the patient from the ER**. These should be directed to the MCR resident (except**

weekends 9 am to 4:30 pm). However, if the patient sounds like they cannot go home and should be admitted to Medicine, then the SMR should see the consult.

13. Stroke Patients: 2021 - (revised) Stroke Admission Guidelines

1) Acute Stroke consults within 24H of symptom onset - first consult Stroke Neurology (this is best practice to ensure we don't miss a Large Vessel Occlusion)

2) Subacute Stroke consults, (greater than) > 24H since symptom onset - go to Stroke Neurology IF any of the following are TRUE:
- imaging positive explaining the symptoms
- imaging negative but the patient has a clear stroke syndrome/deficit on exam as supported by history (e.g. early lacunar stroke may be negative on imaging but the patient has a clear stroke syndrome, e.g. face + arm + leg weakness)

Other Query Subacute Stroke consults, where imaging negative or who don't have a clear stroke syndrome, go to Internal Medicine. When/if stroke is confirmed, stroke will accept and transfer care, to the stroke unit for comprehensive allied health care. Only exceptions include patients who need higher levels of care (level 1,2,3 ICUs), or if there is a more urgent/precedent primary medical issue.

Please tell the chief resident chiefresident@sunnybrook.ca if there are any issues with the stroke guidelines so that we can work with our Stroke Neurology colleagues to troubleshoot. Stroke Unit Admission Policy link:
https://sunnynet.ca/data/1/rec_docs/17214_Stroke_Unit_Inclusion_criteria_KB_edits.pdf

14. Four Hour Rule

There is an Ontario Provincial Initiative in which patients should have a disposition decision within 4 hours of referral to a specialty service. **Please remember that 4 hours is only a guideline**. **Some consults will go quicker and other consults will take longer.** We recommend completing the GIM Standardized Admission Orders as soon as you know that the patient will be admitted (i.e., you do not need to wait for your clerk or intern to complete the consult). Patient safety is still the priority, and if you need more time to assess a sick patient do not hesitate to involve the ICU or your staff to help. Please also document in the "Doctor's Orders" when you arrive to assess the patient. You should be there to assess within 1 hour of receiving the consult.

15. ED1 Holds and Social Holds

ED 1 HOLDS

Patients may be referred to GIM to be held for allied health assessment. In these cases, the patient does not have acute medical concerns, but is unable to go home (mobility issues, home safety concerns). During the daytime, the ER may refer these patients directly to the ED1 team. You may also refer to ED1 if you have been consulted by ER, done the consult, believe they do not have medical issues necessitating admission, but need allied health assessment prior to discharge home. The ED1 pager is **7120** and can be reached between 0800-2300, 7 days a week. Overnight, the ER will refer a patient to be "held for ED1 assessment" if there will be handover between more than three ED physicians (i.e., two or more handovers between ED team). In this situation, it is your duty to assess the patient and write a consult note, then decide the following:

a. If the patient is medically stable with no reason for medical admission: **This is an ED1 Hold.** Order home medications, write **"Hold for ED1 assessment**" in the orders, add the patient to your team list, and inform the nurse of this plan. In the consult note and orders, please include the colour team under which the patient is being held. ED1 Holds should usually be held under the team on call that day; they should never be held under Orange/Purple/Silver. DO NOT ADMIT the patient if you are holding them purely for ED-1 assessment. During the daytime, you must **PAGE the**

ED1Team at 7120 (not sufficient to just write an order in the chart). Please also tell the CL in ED that you are doing this so that he/she is aware of the plan.

b. If the patient has a medical reason for admission after your assessment: **Admit as per usual protocol**

SOCIAL HOLDS: If the patient has no acute medical concerns and needs no investigations but are unable to return home, then they should be admitted BUT the reason for admission MUST be **"SOCIAL HOLD"**, and they should be made ALC. Usually the ED physician and team will have determined this prior to request for consultation (and they may ask you to "admit for social hold"), but you can also make this determination which should be done in discussion with your staff.

These are relatively rare admissions, and typically would be for patients with advanced dementia who are presenting due to progression of care needs or care giver burnout, not being managed with current supports. Or potentially for patients with heavy care needs who have recently left hospital who need more supports, that seems to be beyond what was set up at discharge, but without new medical issues. These patients will be held in the ED with urgent placement arranged. This means they must be totally stable and no tests required.

16. Late Referrals (06:00 to 08:00)

As much as possible, consults received after approximately 6am should be held for the fresh, incoming team. If the patient being referred at that time is unstable, or needs urgent attention for any reason, the patient must be seen without delay. If the patient is stable and can wait for a full assessment, the senior should still see and write appropriate immediate orders (e.g. antibiotics, fluids, furosemide) and let the patient know about the handover process. The hospital policy is that all consults must be started within one hour of receipt; the ER will not 'hold' consults. You should hand over any patient in detail to the daytime consults team promptly at 8 AM and indicate the length of time since referral so that they can prioritize.

17. Orange Team

Orange Team accepts daytime admissions and ICU transfers. In the evenings and weekends, Orange accepts:

a. Admissions to K3E (if beds available)
   i. **New July 2024:** Overnight K3E admissions will be completed by the **MCR**
   ii. **No telemetry or negative pressure isolation (e.g. TB, measles, disseminated zoster)**, otherwise can admit any medicine patient including PUI/COVID patients if an isolation room is available.

Orange Fellow Bridge Shift (Has not yet started for 2025-2026 academic year)

Since Spring 2023, an Orange Hospitalist Fellow is available most days on weekday evenings from 12-8PM. The Bridge Fellow will typically assist with 1-2 late PM admission (~4-5PM) that would otherwise be held for the incoming SMR. The Bridge Fellow should prioritize admitting to K3E (Orange) or Silver Team, or if there are no Orange/Silver beds to the ON-CALL CTU team. They should aim to be done by around 7PM to facilitate time for handover/review. Any admissions to the ON-CALL CTU Team should be reviewed in REAL TIME with the On-Call staff and handover must be given to the on-call SMR/clerks covering that team. Any admissions to Silver or Orange should be handed over to the MCR or overnight Orange Fellow, respectively, to be reviewed in the morning.

18. Trauma Admissions at SBK

PATIENTS PRESENTING TO ED BY TRAUMA PROTOCOLS – IMPORTANT – PLEASE READ (at least the bolded stuff)

a. The following agreement has been agreed upon with the Chief of the Trauma Program and aligns with already existing ED admission/consultation guidelines: if a patient arrives as a trauma and we are asked to consult for admission, as they have no traumatic injuries but cannot be discharged due to medical concerns, then one of the two following scenarios should happen:
    i. **Patient lives <u>WITHIN</u> or sustained their "trauma" within our catchment – GIM should see for consideration of admission**
    ii. **Patient lives <u>OUTSIDE</u> our catchment area – trauma service will admit, with GIM Med Consults to see for initiation of work up and medical management, and the trauma service to arrange repatriation to the patient's home hospital (to be determined by patient flow)**
b. Obviously as there is some complexity to this, **on-call senior residents are strongly encouraged to contact their staff for <u>any</u> patient they are asked to see for consideration of admission (transfer of care) from the trauma service** (or other surgical service if arrived as a trauma)
c. During weekday daytime hours, these discussions should be handled by the Consults Staff. For out of hours (overnight and on weekends, and a patient arrives by EMS trauma protocol and GIM is being requested to see for admission, unless the trauma service clearly shows they are from our catchment, **<u>it is most appropriate for trauma to admit with medical consults to see for medical issues</u>** and transfer consideration can be discussed at a staff-to-staff level in the morning.
d. **<u>Postal Codes for SB catchment area (need not be memorized but for reference if needed):</u>**
    i. M5M, M5R, M4N, M4S, M4W, M2L, M5N, M4G, M4P, M4T, M3B, M2P, M5P, M4H, M4R, M4V, M3C

ICU to Medicine Transfer Protocol – For patients currently in an ICU unit

*ICU transfer requests should only be received by the Senior Resident or Staff. The full consult/transfer can be completed by an intern but it must initially be 'eye balled' by a staff or senior resident (and reviewed after completion).

When the critical care (CrCU, B5ICU, D4ICU, CVICU) team (physicians and nurses) identifies a patient who in their view is ready for transfer to General Medicine:

1. ICU CCL puts a request in the bedflow system.
2. Once a GIM bed has been identified, the ICU will be notified, and they will contact the GIM staff on call (if during the day) or the medicine senior (if overnight).
3. The medicine staff or overnight SMR will then identify which team will be accepting the patient (according to the ward to which the patient will be transferred).
    a. If during the day, the GIM consults team will typically do the transfer. If the consults team is very busy or the patient is already known to the team they are transferring to, then they can discuss with the CTU staff to see if they can help with doing the transfer.
    b. If overnight, the SMR will help the associated team's resident facilitate the transfer (i.e., triage the consult, assign to junior, review with junior). The junior resident on the team may be called. The junior MUST redirect these pages to the SMR on call.
4. Medicine doctor sees patient, completes orders for appropriate patients in a timely fashion.

***If ICU patients are still the ER**, the daytime consults team will be consulted during weekdays; if overnight, the SMR will be consulted. A GIM ward bed does <u>not</u> need to be identified prior to GIM referral from ICU, and the patient can be admitted to any team if a specific ward is not yet identified.

<u>FAQ</u>

Updated April 2025

1. **Admission criteria overnight for Orange Team/what can Orange Team admit?**
    a. Overnight, the MCR admits patients to the K3E ward (**no telemetry/airborne isolation**), if beds are available. Orange does not have any other MRP beds in the main hospital. The Orange Team bridge fellow (if available) or MCR overnight reviews these admissions directly with the Orange Team staff, timing of review at discretion of Orange Team fellow and staff.

2. **Does the SMR have to review with Orange Team?**
    a. The SMR is not required to review admissions by the Orange Fellow/MCR to K3E but should be available to support, if required.
    b. If an Orange team admission is completed by a JMR, this can be reviewed with either the MCR or SMR depending on workload. If reviewed by the SMR, there is **no need** to involve the MCR, and the junior or SMR should hand over the case to the overnight Orange fellow directly to then handover to Orange staff in the morning. The JMR should be available for questions from the Orange staff in the morning, if required, but will not do a full review with the Orange staff for that consult.

3. **Who does the Orange Bridge Fellow Admit to?**
    a. There may be a Bridge Fellow present on weekdays from **12-8PM during the first half of the year,** and after 4PM can admit to **Silver** Team, **Orange** Team, or the **On-Call CTU** team. They may have consults already assigned by the time you start your SMR call shift.
    b. The Orange Bridge Fellow will review directly with the staff On-Call for the admitting team.
    c. The Orange Bridge Fellow should provide handover to the covering on-call resident for whichever team they admitted patients to (i.e MCR (Silver), K3E Orange Fellow on call, on-call SMR/clerks).

4. **What do I do if there are no Level 1 ICU beds available?**
    a. Do not hesitate to involve your On-Call Staff to discuss and consider possible transfers between Level 1 ICU and the ward
    b. If the 6 Level 1 ICU beds on C4 are full, and there is no patient confirmed to be able to come out of the Level 1 ICU, then the ICU team should be contacted and you should NOT do a consult. **The exception, starting Oct 1 2025, is for DKA. We are running a pilot project where patients with DKA can be admitted to L1 even if there is no bed available (provided that there is no reason for admission to another service).** The patient will be continued to be cared for in the ED until a bed becomes available.

5. **Who do the weekend Daytime Consults Seniors review admissions with? Who do they admit to?**
    a. Patients that are to be discharged should be reviewed with the **on-call GIM staff.**
    b. Patients that are being admitted from the ED or transferred from ICU to the **respective CTU colour team** should be reviewed with the **attending staff** (i.e new ED admission to Green Team should be reviewed with the Green Team staff). Patients should start by being admitted to the team with the lowest census or the on-call team unless otherwise informed by your staff/CMR
        i. Patients who are being admitted should also be signed over to the **resident** covering that team with specific items for follow-up clearly conveyed.
    c. New Med Consults seen by the daytime Consults senior should be reviewed with the **Med Consults Staff** → find the Med Consults staff through locating by searching "**Ward Med Consults**".

6. **Who can admit to/be admitted to Silver Team**?
    a. Admissions to Silver Team should primarily be done by the MCR resident on call, but if MCR is busy any juniors can admit to Silver. These consults should be reviewed with the SMR and subsequently handed over to the MCR resident if the MCR is not available to review directly, and the MCR should tell the Silver Staff about the patient in the AM.

b. Admitting to Silver overnight:
    i. **Short stay patients (anticipated admission <72 h) should be prioritized for Silver**
    ii. CTU staff on call will direct SMR regarding the number of admissions to Silver (and whether the offload CTU Silver beds –i.e. not necessarily short stay – can be admitted to overnight)

7. Who can clerks admit to?

a. Clerks should only be admitting to their own teams (so that they are able to review with their staff and can follow the patients longitudinally).

8. Do I have to fill the open Orange/Silver beds <u>first</u> during the night?

a. No! It is most helpful for everyone's learning to be admitting to their own teams, and often MCR is busy at the start of the night.
b. A suggested possible algorithm: have each junior/medical student admit a patient to their own team, and then start assigning to Orange/Silver

9. Do I have to fill all open Orange/Silver beds overnight?

a. If it is possible to fill them at some point in the night, then great, but if not, that is okay!
b. If possible, try to balance this with the number of consults you are getting and avoid extremes (e.g. it is less ideal to have 20 patients admitted that all go to CTU teams with 20+ censuses and leave 5 open Orange beds at the end of the night)
c. Orange beds are usually the priority to fill over Silver beds (e.g. if there are 2 Orange beds and 2 Silver beds, try to fill the Orange beds before the Silver beds if appropriate patients)

10. What if there are lots of open Orange/Silver beds? Note this happens rarely as we try to fill these during the day.

a. As above, consider admitting one patient to each CTU team first so that juniors have some continuity of care for the patients they are admitting
b. Prioritize the MCR admitting to these beds, but balance with the rest of the team's workload (e.g. if you had 8 total consults overnight, it would not be ideal for MCR to do 4 admissions while the junior residents/clerks did 1 each)
c. It is not the expectation that MCR is the resident that admits to and fills every single open Orange/Silver bed (as they are often busy with subspecialty consults!)